STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	08A006	A. BUILDING _____ B. WING _____	10/09/2009

LTC Residents Protection
OCT 28 2009
Director's Office

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JEANNE JUGAN RESIDENCE	185 SALEM CHURCH ROAD NEWARK, DE 19713

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS An unannounced QIS annual survey was conducted at this facility from October 5, 2009 through October 9, 2009. The deficiencies contained in this report are based on observation, interview, review of residents' clinical records and review of other documentation as indicated. The facility census the first day of the survey was 39. The survey sample totaled 59 residents, which included 39 census residents, 2 admission residents and 18 stage 2 residents.	F 000	.The DON in-serviced LPN # 2 of correct dressing change practices and witnessed a correct dressing change for Resident # 16 on 10/9/09 All Residents have the potential to be affected unsafe dressing changes Many of the nursing staff were in-serviced on the clean dressing change policy on 10/21/09. See attachments A & B The remainder of the nursing staff will be in-serviced on the Clean Dressing Policy by 11-20-09 Dressing Changes will be observed monthly on a random basis and findings reported Skin Care Meetings. The first report will be on 11/2/09. See attachment C	10/9/09 10/21/09 11/20/09 11/2/09
F 314 SS=D	483.25(c) PRESSURE SORES Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing. This REQUIREMENT is not met as evidenced by: Based on clinical record review, review of facility policy and procedure, observations and interview, it was determined that the facility failed to ensure that 1 (one) resident (R16) out of 18 stage 2 sampled, received necessary treatment and services to promote healing and prevent infection of a sacral pressure sore. LPN #2 failed to observe clean wound dressing technique for R16. Findings include: The facility's Policy entitled "Dressing, Transparent" was reviewed.	F 314		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Sr. Celestine Meade	Administrator	10-27-09

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	08A006	A. BUILDING _____ B. WING _____	10/09/2009

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JEANNE JUGAN RESIDENCE	185 SALEM CHURCH ROAD NEWARK, DE 19713

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 314	Continued From page 1 R16 was observed receiving wound treatment for a Stage 3 pressure ulcer on 10/8/09 at 2:00 PM.The wound treatment supplies were as follows: Normal Saline Solution - for cleansing the wound Hydrogel and 2x2 tegaderm transparent dressing and a plastic bag. The following were observed during the wound dressing treatment provided by LPN#2 on 10/8/09 at approximately 2:00 PM: A treatment caddy (where wound treatments supplies were stored) was observed on top of the resident's bedside table. LPN#2 did not prepare a clean field. Instead LPN#2 incorrectly reached inside the treatment caddy several times with contaminated gloves. R16 was assisted in bed, and was turned on her left side by LPN #2. LPN #2 was not observed washing her hands prior to donning a pair of gloves to remove soiled dressings to expose the sacral pressure sore. LPN#2 donned a second pair of clean gloves without handwashing thereby contaminating the gloves. She then reached for the small plastic vials of normal saline solution from the caddy with her contaminated gloves. LPN #2 cleansed the sacral wound with normal saline solution by squirting it over the wound. However, she did not separate the sacral folds to exposed the wound and to ensure that the wound was thoroughly cleansed. LPN#2 changed gloves again without handwashing and reached for the package of the hydrogel gauze inside the treatment caddy, opened it and inserted the hydrogel gauze into the sacral wound. Again, with a contaminated gloves, she reached for the Tegaderm	F 314		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	08A006	A. BUILDING _____ B. WING _____	10/09/2009

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JEANNE JUGAN RESIDENCE	185 SALEM CHURCH ROAD NEWARK, DE 19713

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 314	Continued From page 2 (transparent dressing cover) inside the caddy and before applying the Tegaderm to cover the wound site, LPN #2 needed a pen to label the Tegaderm dressing cover. LPN#2 opened R16's bedside drawer with her contaminated gloves in search of a pen in order to label the Tegaderm dressing. LPN#2 failed to maintain clean technique during the wound dressing change when she changed gloves 3 times without handwashing. In an interview with RN #3 on 10/09/09 at 10:30 AM, she acknowledged that LPN#2 should have taken the necessary wound dressing supplies that she needed for the wound dressing to the resident's room instead of the whole treatment caddy. RN#3 also acknowledged that LPN #2 failed to observe clean wound dressing technique.	F 314	Resident #24 was being monitored for anti-depressant via a flow sheet on the MAR and nurses notes detailed monitoring for the use of the anti-anxiety medications. Resident # 24 is not on anti-psychotic drug therapy. A flow sheet was added to the MAR for monitoring of the anti-anxiety medication. The name of the drug was changed on the flow sheet for monitoring anti- depressants. All Residents have the potential to be affected lack of monitoring of psycho tropic drugs.	10/10/09
F 329 SS=D	483.25(l) UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above. Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically	F 329	Many of the nursing staff were in-serviced on the need to monitor psychotropic medications on 10/21/09. See attachment A The remainder of the nursing staff will be in-serviced on the need to monitor psychotropic medications by 11-20-09 Monthly MAR reviews will be conducted by the ADON to ensure accurate monitoring of psychotropic medications and results reported at quarterly CQI meetings. The first review was completed on 10/20/09 by the DON and reported at CQI on 10-21-09	10/21/09 11/20/09 10/20/09 10/21/09

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	08A006	A. BUILDING _____ B. WING _____	10/09/2009

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JEANNE JUGAN RESIDENCE	185 SALEM CHURCH ROAD NEWARK, DE 19713

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 329	Continued From page 3 contraindicated, in an effort to discontinue these drugs. This REQUIREMENT is not met as evidenced by: Based on clinical record review and interview, it was determined that the facility failed to monitor 1 (one) resident's (R24) out of 18 stage 2 sampled, behaviors and potential side effects of the antianxiety drug Ativan (Lorazepam) and the antidepressant Remeron. There was no evidence the facility provided non-pharmacological behavior interventions prior to administering the Ativan to minimize adverse consequences. Findings include: R24 had diagnoses that included anxiety and depression. R24 had a physician's order dated 9/14/09 for Lorazepam (Ativan) 0.5 mg. tablet 1/2 a tablet (0.25 mg) PO (by mouth)at bedtime for anxiety and 0.5 mg 1 tablet PO every 6 hrs. as needed for anxiety. In addition, on 9/30/09, R24 was prescribed an additional dose of "Ativan 0.25 mg PO QD (daily) at 4 PM and the anti-depressant "Remeron 7.5 mg. by mouth at bedtime x 7 days" and then to "increase to 15 mg. by mouth at bedtime". According to a "Psychiatry-follow up" evaluation dated 9/30/09, R24 continued to experience some episodes of anxiety and "tearful" at times when she talked about her family and identified the presence of anxiety and depression. On 10/09/09, review of the 9/09 and 10/09 Medication Administration Record (MAR) revealed lack of behavior monitoring for the antianxiety drug Ativan. Review	F 329		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	08A006	A. BUILDING _____ B. WING _____	10/09/2009

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JEANNE JUGAN RESIDENCE	185 SALEM CHURCH ROAD NEWARK, DE 19713

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 329	Continued From page 4 of the 10/09 MAR also revealed that the anti-depressant Remeron was initiated on 10/8/09 but lacked documented evidence that behavior monitoring was initiated. Additionally, the facility failed to list and document non-pharmacological behavior interventions in addition to the medication to minimize any adverse consequences. In an interview with RN#2 (Assistant Director of Nursing-ADON) on 10/10/09, she acknowledged that the facility lacked documented behavior monitoring related to R24's anti-anxiety for 9/09 and 10/09. Additionally, the facility failed to initiate behavior monitoring for the anti-depressant Remeron drug which was initiated on 10/8/09.	F 329		
F 428 SS=D	483.60(c) DRUG REGIMEN REVIEW The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. The pharmacist must report any irregularities to the attending physician, and the director of nursing, and these reports must be acted upon. This REQUIREMENT is not met as evidenced by: Cross-refer to F329 Based on clinical record review and interview, it was determined that during the monthly drug regimen review, the licensed pharmacist failed to identify and report that 1 (one) resident (R24) sampled, who was receiving Ativan, lacked	F 428	Cross refer to F329 Resident #24 was being monitored for anti-depressant via a flow sheet on the MAR and nurses notes detailed monitoring for the use of the anti-anxiety medications. Resident # 24 is	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	08A006	A. BUILDING _____ B. WING _____	10/09/2009

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JEANNE JUGAN RESIDENCE	185 SALEM CHURCH ROAD NEWARK, DE 19713

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 428	Continued From page 5 behavior monitoring. Findings include: Review of R24's clinical record revealed that this resident was receiving Ativan 0.25 mg. BID (twice a day) since 8/26/09. However, there was no evidence that behavior monitoring was done. Review of R24's " Medication Regimen Review" sheet indicated that a licensed pharmacist had completed a review on 9/14//09 but failed to identify and report R24's lack of behavior monitoring. Additionally, the Ativan was again prescribed on 9/14/09 and initiated on 9/14/09 . In addition, the antidepressant Remeron was prescribed on 9/30/09. An interview with RN#22 (ADON) on 10/10/09 revealed that the Pharmacy sends the facility printed behavior monitoring forms for each resident receiving anti-psychotic and anti-depressant medications. This is the facility's system to ensure the monitoring of behaviors on residents who were receiving antianxiety and anti-depressant medications. In an interview with RN#2 on 10/09/09, she stated that the Pharmacy was aware that R24 was receiving the Ativan and the Remeron but failed to send the printed behavior monitoring form for R24 to the facility in a timely manner thus the drug monitoring was not done.	F 428	not on anti-psychotic drug therapy. The Pharmacy sent a flow sheet which was added to the MAR for monitoring of the anti-anxiety medication. The name of the anti-depressant drug was changed on the flow sheet for utilized for monitoring anti- depressants. All Residents have the potential to be affected lack of monitoring of psycho tropic drugs. Printed behavior forms were sent from the Pharmacy and the facility now has blank form so that forms can be put in place when new psychotropic drugs are ordered. Many of the nursing staff were in-serviced on the need to monitor psychotropic medications on 10/21/09. See attachment A The remainder of the nursing staff will be in-serviced on the need to monitor psychotropic medications by 11-20-09 Monthly MAR reviews will be conducted by the ADON to ensure accurate monitoring of psychotropic medications and results reported at quarterly CQI meetings. The first review was completed on 10/20/09 by the DON and reported at CQI on 10-21-09	10/10/09 10/21/09 11/20/09 10/20/09 10/21/09
F 514 SS=B	483.75(l)(1) CLINICAL RECORDS The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized.	F 514		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	08A006	A. BUILDING _____ B. WING _____	10/09/2009

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JEANNE JUGAN RESIDENCE	185 SALEM CHURCH ROAD NEWARK, DE 19713

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 514	Continued From page 6 The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes. This REQUIREMENT is not met as evidenced by: Based on record review and interview, it was determined that the facility failed to ensure that clinical records on four (4) residents (R12, R19, R21 and R44) out of 39 census sampled were maintained in accordance with accepted professional standards of practice that were complete and accurately documented. Findings include: 1. R12 had a physician's order for Fruit Resource drink 120 cc BID (twice a day) dated 8/18/09. There were no signatures in the 9/09 MAR (Medication Administration Record) to indicate that this resident received the Fruit Resource drink. Additionally, from 10/1 through 10/4/09 four (4 days) including HS (bedtime) on 10/5/09 also were not signed off as given. 2. R19 had a physician's order for Health Shakes 60 cc BID w/medication pass. Review of R19's MARs revealed that the Health Shakes were not transcribed on the 9/09 and 10/09 MARs and therefore lack documentation that the resident received the supplement. 3. R21 had a physician's order dated 9/17/09 for Fruit resource drink 120 cc. BID. Review of the 9/09 MAR with LPN #1 revealed that the	F 514	Supplements were added to the MAR for Residents # 12, 19, 21 and 44 on 10/5/09. Resident # 44's physician order for pro-cell was corrected and accurately transcribed to the MAR on 10/6/09. All Residents have the potential to be affected by not having supplements accurately on the MAR. Many of the nursing staff were in-serviced on the need to ensure that supplements are recorded on the MAR.. See attachment A The remainder of the nursing staff will be in-serviced on the by 11-20-09 need to ensure that supplements are recorded on the MAR.. See attachment B The Pharmacy will begin printing nutritional supplement orders on the MAR on a routine medication administration page in December 2009. The Dietician will review nutritional supplement orders monthly to ensure all orders are accurate and documentation is correct and report findings at quarterly CQI meetings. The first review and report to CQI was done on 10/21/09 by the DON	10/5/09 10-6-09 10/21/09 11/20/09 12/1/09 10/21/09

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	08A006	A. BUILDING _____ B. WING _____	10/09/2009

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JEANNE JUGAN RESIDENCE	185 SALEM CHURCH ROAD NEWARK, DE 19713

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 514	Continued From page 7 supplement was not signed off from 9/17/09 through 9/30/09. Additionally, the Fruit Resource supplement was not transcribed on the 10/09 MAR and therefore there was no documentation that this resident received the supplement from 10/01/09 through 10/6/09. 4. R44 had a physician's order dated 9/26/09 for Pro-cel-protein supplement 2 scoops BID (two times a day) + fruit resource-120 cc TID (three times a day). Review of the 10/09 MAR revealed the following: The supplements were not signed off from 10/1/09 through 10/5/09 for 5 PM (5 days); 10/2/09 was not signed off for 8 AM; fruit resource was not signed off on 10/1/09 and 10/05/09 at 9AM and 1 PM. In addition, in an interview with LPN#1 on 10/6/09 at 2:45 PM acknowledged that the Pro-cell supplement was transcribed once a day instead of BID and therefore was only documented as given once a day instead of twice a day. LPN#1 acknowledged these findings on 10/6/09.	F 514		

DELAWARE HEALTH AND SOCIAL SERVICES
Division of Long Term Care Residents Protection

DHSS - DLTCRP
3 Mill Road, Suite 308
Wilmington, Delaware 19806
(302) 577-6661

STATE SURVEY REPORT

NAME OF FACILITY: Jeanne Jugan

DATE SURVEY COMPLETED: October 9, 2009

SECTION	STATEMENT OF DEFICIENCIES Specific Deficiencies	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES WITH ANTICIPATED DATES TO BE CORRECTED
	An unannounced QIS annual survey was conducted at this facility from October 5, 2009 through October 9, 2009. The deficiencies contained in this report are based on observation, interview, review of residents' clinical records and review of other documentation as indicated. The facility census the first day of the survey was 39. The survey sample totaled 59 residents, which included 39 census residents, 2 admission residents, and 18 stage 2 residents.	
3201	**Skilled and Intermediate Care Nursing Facilities**	
3201.6.0	**Services To Residents**	
3201.6.1	**General Services**	
3201.6.1.1	**The nursing facility shall provide to all residents the care necessary for their comfort, safety and general well-being, and shall meet their medical, nursing, nutritional, and psychosocial needs.** **This requirement is not met as evidenced by:** Cross-refer to CMS 2567-L, survey date completed 10/9/09, F314, F329 and F428.	Cross reference to CMS 2567-L survey date completed 10/9/09, F314, F329, F428

Provider's Signature A. Celestine Meade Title Administrator Date 10/27/09

DELAWARE HEALTH AND SOCIAL SERVICES
Division of Long Term Care Residents Protection

DHSS - DLTCRP
3 Mill Road, Suite 308
Wilmington, Delaware 19806
(302) 577-6661

STATE SURVEY REPORT

NAME OF FACILITY: Jeanne Jugan

DATE SURVEY COMPLETED: October 9, 2009

SECTION	STATEMENT OF DEFICIENCIES Specific Deficiencies	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES WITH ANTICIPATED DATES TO BE CORRECTED
3201.6.10	**Records and Reports**	
3201.6.10.1	**There shall be a separate clinical record maintained on each resident as a chronological history of the resident's stay in the nursing facility. Each resident's record shall contain current and accurate information including the following:**	
3201.10.1.7	**Medication administration record (MAR) including medications, dosages, frequency, route of administration, and initials of the nurse administering each dose. The record shall include the signature of each nurse whose initials appear on the MAR.** **This requirement is not met as evidenced by:** Cross refer to CMS 2567-L, survey date completed 10/9/09, F514.	Cross reference to CMS 2567-L survey date completed 10/9/09 , F514